number missed in the whole colon is approximately twice these numbers. Thus a large portion of people with disease are falsely reassured; indeed the number falsely reassured exceeds the number of true positives.

Although FOBS will clearly detect some colorectal cancers and precancerous polyps, it cannot be considered an inexpensive procedure. In fact, one study has shown FOBS to be less than one-twentieth as cost effective as flexible sigmoidoscopy (Anderson JP, Ganiats TG, Kazemi MM: Screening and treatment for colorectal cancer: A benefit-cost/utility comparison of flexible sigmoidoscopy and fecal occult blood methods using the General Health Policy Model, unpublished data). Unfortunately, enthusiasm for FOBS has not awaited a reevaluation of its cost effectiveness, and over-the-counter FOBS interventions done without medical supervision are likely to muddy the waters further. In this age of cost-containment it is incumbent upon the public and the medical community to reevaluate the cost effectiveness of fecal occult blood screening for colon cancer.

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REFERENCES

1. Brendler SJ, Tolle SW: Fecal occult blood screening and evaluation for a positive test. West J Med 1987; 146:103-105
2. American Cancer Society: Guidelines for the cancer-related checkup: Recommendations and rationale. CA 1980; 30:194-240
3. Eddy DM: Screening for cancer: Theory, analysis and design. Engelwood Cliffs, NJ, Prentice-Hall, 1980
4. Day DW, Morson BC: The adenoma-carcinoma sequence, Chap 6, *In* Morson BC (Ed): The Pathogenesis of Colorectal Cancer. Philadelphia, WB Saunders Co, 1978, pp 58-71
5. Frank JW: Occult blood screening for colorectal carcinoma: The risks. Am J Prev Med 1985; 1(4):25-32
6. Simon JB: Occult blood screening for colorectal carcinoma: A review. Gastroenterology 1985; 88:820-837

Was It Worth It?

TO THE EDITOR: This is in response to your editorial "$250,000—Was It Worth It?" in the January issue.[1] In the case report you discuss,[2] a habitual intravenous drug abuser survived nine admissions for mitral valve endocarditis, including two valve replacements, accumulating more than one hospital-year out of the past 12 years. Was spending all that money on this loser worth it? Did other people, more deserving of health care, not get it because of him?

I wonder how much of your skepticism stems from moral considerations about this patient's worth to society. I have trouble imagining that you would make a similar remark about a case report of a housewife with an exceptional case of systemic lupus, who survives repeated hospital stays and runs up a huge bill that society must pay.

I confess that I do not feel entirely sanguine about cases like this either. I pay taxes too, and thank goodness that there are not more patients like this fellow than there are. I believe, however, that we must resist firmly any effort to put us medical doctors in the position of judging who is fit to be treated, and who is condemned to be declared surplus. I have seen scenarios like that in Orwellian science fiction stories.

When I am faced with moral dilemmas such as are exemplified by this case, I remember a quotation from Mencken: "The purpose of the medical profession is not to make men virtuous. It is to rescue them from the consequences of their vices."

I emphasize that I am addressing the idea of whether to decide to treat on the basis of the patient's moral worth. I do not advocate futile treatment that needlessly prolongs suffering.

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REFERENCES

1. Watts MSM: $250,000—Was it worth it? (Editorial). West J Med 1987 Jan; 146:86
2. Simonson J, Schaaf VM, Mills J: Nine episodes of infective endocarditis in one patient—A new record. West J Med 1987 Jan; 146:96-98

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TO THE EDITOR: I read your editorial in the January 1987 issue: "$250,000.00—Was It Worth It?"[1] I do not believe it was worth it.

An individual has a right to do anything to his body he cares to do. However, when a physical abuse that is self-inflicted becomes a financial burden on me (society), then that right ceases. We all know that in all aspects of our lives we can do anything we care to do as long as we do not violate the rights of others. When a person abuses his body, that is his right. When he abuses it to the point of seeking health care and I am financially responsible, then he violates my rights.

The answer to your question—"Was It Worth It?"—is no. In instances of physical abuse that is self-inflicted where there is no financial responsibility, the individual person seeking treatment should simply be given a comfortable place in the hospital where the person is maintained, and if he survives, he survives. If he does not, he does not. This would save vast sums of money spent on a hopeless problem, allowing the expenditure of the same money in needed areas. For those who are financially responsible—for instance, with medical insurance—there should be surcharges to cover the added costs incurred by their physical self-abuse. I note that some insurance companies are already headed in that direction, giving discounts for nonsmokers and nondrinkers.

The problems of physical self-abuse will always be with us. The financial responsibility for that abuse should be placed squarely on the person abusing himself. Just possibly not spending the money on those who do abuse themselves would reduce their numbers so that others who really need health care would have funds available.

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REFERENCE

1. Watts MSM: $250,000—Was it worth it? (Editorial). West J Med 1987 Jan; 146:86

Natural Death Acts

TO THE EDITOR: I am writing regarding the Commentary "Nora's 'Living Will' " by Dr E.R.W. Fox in the January issue.[1] It was sensational!

We here in the state of Washington are wrestling with revisions of a "natural death act" that, we hope, ought to be adopted this year. Moreover, the Washington State Medical Association has agreed to "push" discussion time about living wills and death and dying with patients so that the issue

"escapes from the closet." Dr Fox's capsulization of his quandary should certainly help broaden the understanding of the issues involved.

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1. Fox ERW: Nora's 'living will.' West J Med 1987 Jan; 146:118

Cognitive-Procedural Differences

TO THE EDITOR: The letter[1] by Stephen D. Leonard, MD, on the concept of cognitive versus procedural care that was published in the February 1987 issue is as remarkable for its prejudice as it is for its ignorance.

The American Society of Internal Medicine and others have unceasingly pointed out that *all* physicians do cognitive work. The question is not that one kind of physician is smarter than the next, but rather that remuneration is so unequal when procedural and nonprocedural services are rendered. This has led to an increasing disparity in income between the primary care and other branches of medicine.

Attempts to adjust cognitive-procedural differences are really an attempt to *avoid* a war among the branches of medicine by making adjustments that bring remuneration more into line with the resource cost of producing medical services.

There may possibly be a better way of labeling the problem than calling it "cognitive-procedural," but to treat it with contempt is to virtually say "Let them eat cake." Who is it, then, who is trying to produce discord within the house of medicine?

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REFERENCE

1. Leonard SD: Concept of cognitive versus procedural (Correspondence). West J Med 1987 Feb; 146:235

Illness From Organophosphate Exposure

TO THE EDITOR: The comparison of cholinesterase values before and after oxime administration, suggested by Izraeli and co-workers,[1] is a clever approach to the confirmation of organophosphate-induced pesticide illness in the absence of preexposure cholinesterase values.

This method will not work in all cases, however.

Persons who become ill after exposure to organophosphates may receive pralidoxime without any substantial effect on their cholinesterase levels, if they have had chronic exposure to these pesticides. This would result from preexisting but nonsymptomatic inhibition of cholinesterase activity—that is, a patient with a substantial portion of the enzyme already irreversibly bound to insecticide.

Neither this method, nor the method we have described,[2] overcomes the limitations of the cholinesterase analysis, which preclude it from being the means of excluding the diagnosis of pesticide poisoning. Carbamate insecticides cause cholinesterase inhibition and cholinergic symptoms, but such inhibition cannot be detected by a cholinesterase analysis, as the bond between enzyme and insecticide is so labile that activity is restored by the analytic procedure. We wonder whether the test may be inadequate to detect symptomatic but mild cases of organophosphate-induced illness as well.

Izraeli and co-workers have, however, provided another useful clinical tool. A minor criticism of their letter is to note that oxime therapy does not necessarily reactivate erythrocyte cholinesterase to a greater degree than plasma cholinesterase. In some cases, it is the plasma cholinesterase that has shown the greater reactivation.[3] This is not surprising in that some pesticides inhibit plasma cholinesterase more dramatically than the erythrocyte enzyme.[4]

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REFERENCES

1. Izraeli S, Glikson M, Ziv I: Diagnosis of organophosphate poisoning (Correspondence). West J Med 1986; 145:698
2. Midtling JE, Barnett PG, Coye MJ, et al: Clinical management of field worker organophosphate poisoning. West J Med 1985; 142:514-518
3. Quinby GE: Further therapeutic experience with pralidoximes in organic phosphorous poisoning. JAMA 1964; 187:114-118
4. Hayes WJ: Pesticides studied in man. Baltimore, Williams & Wilkins, 1982, p 309

Educating the Public About Life-Style and Nutritional Practices

TO THE EDITOR: I would like to make some comments regarding the article in the Forum section entitled "Educate, Educate, Educate" by R. W. Odell, Jr, MD.[1] I heartily agree with Dr Odell that the funding of our health care is forcing a long needed reappraisal of values we as physicians have taken for granted. I also agree that a competent physician educates his or her patients as part of his or her treatment. He states, "American medicine will regain its preeminence in our society only in so far as it reassumes this vital function of educator about matters medical. This will require brutal honesty and much soul searching, for past deficiencies are not easily made up."

I would differ with him, however, on where the emphasis should be on education. All of the things that he points out I think are valid. However, we as physicians must come to the realization that the great majority of our major illnesses are largely self-inflicted by self-destructive life-style and dietary habits. They are, therefore, largely preventable. Our emphasis in medicine has been largely on diagnosis and treatment of established disease. As long as we continue to place the emphasis on ever more sophisticated means of diagnosing and treating diseases, we are only going to drive up the cost of health care. We must find a means of reducing the supply of sick patients. Even the National Cancer Institute has acknowledged that we do not need a single new breakthrough in diagnosis or treatment. If we could just put into practice what we already know about diagnosing and treating disease, and particularly what we know about preventing cancer, and the same may be said of cardiovascular disease, we could greatly reduce the death rate from cancer by the turn of the century. We have already seen a significant reduction in age-adjusted death rates from coronary artery disease as the public has become aware of the relationship of smoking, diet and exercise to cardiovascular disease. Currently in the United States, nearly one half of all people succumb to a single disease process, namely, atherosclerosis, the underlying cause of most heart attacks and strokes. We certainly have sufficient evidence now to realize that atherosclerosis can certainly be minimized if not eliminated by appropriate life-style and dietary practices.